CareFirst BlueChoice

CareFirst BlueCross BlueShield

Health Benefit Options

Charles County Commissioners

Employees

2011-2012

Benefits Comparison Summary

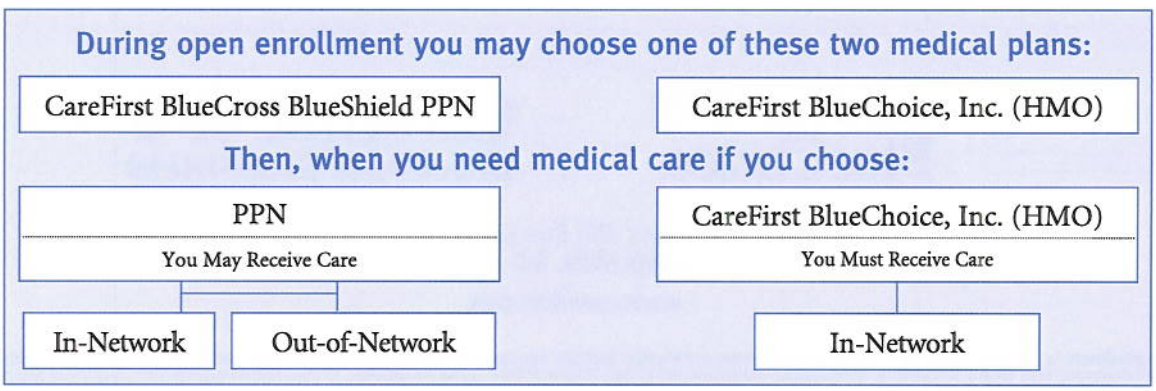
Benefits	PREFERRED PRO In-Network
INPATIENT HOSPITALIZATION	100% up to 365 days
INPATIENT MEDICAL/SURGICAL	100% AB (Allowed Benefit)
EMERGENCY SERVICES (Life Threatening)	ER: Accident - 100% AB within 72 hours ER: Medical Emergency - 100% AB after copay
PRIMARY CARE Office Visit Specialist Office Visit	$15 copay per visit
OUTPATIENT SURGERY	100% AB
MATERNITY CARE	100% AB; Includes Pre- & Postnatal
DIAGNOSTIC X-RAY & LAB	Office - $15 copay per visit Outpatient Facility - $35 copay per visit
WELL CHILD CARE	$15 copay per visit
ROUTINE PHYSICALS	$15 copay per visit
ALLERGY TESTING	100% AB
PHYSICAL/OCCUPATIONAL/SPEECH THERAPY (PT, OT, ST)	100% AB after copay per visit, 100 visits per calendar year
CHIROPRACTIC CARE	$15 copay per visit
RADIATION/CHEMOTHERAPY/RENAL DIALYSIS	100% AB after copay per visit
DURABLE MEDICAL EQUIPMENT	100% AB
PRESCRIPTION DRUGS (When filled by Participating Pharmacies)	$5 copay Generic/$20 copay Formulary Brand $35 copay Non-Formulary Brand 3 copays for 90-day maintenance supply at retail 2 copays for 90-day maintenance supply at mail order
INPATIENT PSYCHIATRIC	*100% up to 365 days
OUTPATIENT PSYCHIATRIC	*$15 copay per visit
ALCOHOL/SUBSTANCE ABUSE REHABILITATION	*See Psychiatric Benefits
PLAN PROVISIONS Copays	$15 Office visit, $25 Practitioner outpatient department, $35 Hospital outpatient department
Calendar Year Deductible	None
Coinsurance	100%
Out-of-Pocket Maximum (Includes Deductible)	$1,000 Individual per year, $2,000 Family Aggregate
DEPENDENT AGE LIMIT	End of the month in which they turn 26
COST CONTAINMENT	N/A

The above serves as a comparison only. Please consult each plan benefit guide for full details, particularly in regard to exclusions, limitations, and additional coverage.
Benefits subject to the contract between CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and Charles County Commissioners.

AB = Allowed Benefit

*Benefits will be managed through Magellan Behavioral Health. All inpatient psychiatric/alcoholism treatment requires preauthorization by Magellan Behavioral Health: (800) 245-7013.

IDER NETWORK Out-of-Network	CAREFIRST BLUECHOICE, INC. (HMO) An Independent Licensee of the BlueCross and BlueShield Association
80% after deductible up to 365 days	Covered in full
80% AB (Allowed Benefit) after deductible	Covered in full
ER: Accident - 100% AB within 72 hours ER: Medical Emergency - 80% AB after deductible	ER: 100% after $25 copay; waived if admitted Urgent Care Center – $5 PCP, $10 Specialist
80% AB after deductible	$5 PCP $10 Specialist
80% AB after deductible	$5 PCP/$10 Specialist
80% AB after deductible; Includes Pre- & Postnatal	$10 copay per visit (up to $100 per pregnancy)
80% AB after deductible	Covered in full
80% AB (deductible waived)	$5 copay per visit
80% AB after deductible	$5 PCP/$10 Specialist
80% AB after deductible	Allergy Testing/Injections/Serum $5 PCP/$10 copay specialist
80% AB after deductible, 100 visits per calendar year	$10 copay, 30 visits per condition, per calendar year
80% AB after deductible	$10 copay; 20 visits per calendar year
80% AB after deductible	$10 copay per visit
80% AB after deductible	Covered in full – no max
$5 copay Generic/$20 copay Formulary Brand $35 copay Non-Formulary Brand 3 copays for 90-day maintenance supply at retail 2 copays for 90-day maintenance supply at mail order	$5 copay Generic/$20 copay Formulary Brand $35 copay Non-Formulary Brand 3 copays for 90-day maintenance supply at retail 2 copays for 90-day maintenance supply
*80% after deductible up to 365 days	*Covered in full
*80% of AB after deductible	*$5 copay per visit
*See Psychiatric Benefits	*See Psychiatric Benefits
N/A	$5 PCP, $10 Specialist, $25 ER
$200 Individual per year, $400 Family Aggregate	None
80%/20%	N/A
$1,000 Individual per year, $2,000 Family Aggregate	N/A
End of the month in which they turn 26	End of the month in which they turn 26
N/A	All cost containment performed by HMO



Summary of Benefits: Select Vision

	Lenses	Frames	Total Allowance
SINGLE	$41.50	$29.50	$71.00
BIFOCAL	$67.00	$29.50	$96.50
TRIFOCAL	$89.50	$29.50	$119.00
CATARACT (APHAKIC)	$156.50	$29.50	$186.00
CONTACT LENSES (PER PAIR)	Medically Indicated*		$221.00
	Cosmetic - Single Vision Lenses		$71.00
BENEFIT PERIOD FOR FRAMES AND LENSES	Benefits for frames, lenses, and contact lenses are available once every 12 months		
Eye Exam	100% of Allowed Benefit (any additional charge for contact lenses exam not covered) Benefit for eye exam - once every 12 months		

* Following cataract surgery or when visual acuity is correctable to at least 20/70 in the better eye only by use of contact lenses.

Summary of Benefits: Regional Traditional Dental

BENEFIT PERIOD DEDUCTIBLES: CLASS II-IV Individual Deductible Family Deductible	 $25 $75
REIMBURSEMENT LEVELS Class I - Preventative & Diagnostic Services	 100% Allowed Benefit (AB), no deductible
Class II - Basic Services Periodontal Services	100% AB after deductible 80% AB after deductible
Class III - Major Surgical Services	80% AB after deductible
Class IV - Major Restorative Services	50% AB after deductible
Class V - Orthodontic Services	50% AB, no deductible
BENEFIT PERIOD MAXIMUM: CLASS I-IV LIFETIME MAXIMUM: CLASS V	$1,500 $1,500
BENEFIT PERIOD	July 1st -June 30th

CareFirst BlueChoice.

CareFirst BlueCross BlueShield

10455 Mill Run Circle
Owings Mills, MD 21117
www.carefirst.com

BRC5176-4S (5/11)